BULLETIN
AMERICAN COLLEGE of SURGEONS

VOL. VII JANUARY, 1923 NO. 2

HOSPITAL STANDARDIZATION SERIES

REPORT OF HOSPITAL CONFERENCE HELD AT BOSTON, OCTOBER 23, 1922

AMERICAN COLLEGE OF SURGEONS
40 EAST ERIE STREET :: :: CHICAGO

BULLETIN

OF THE

AMERICAN COLLEGE *of* SURGEONS

VOL. VII JANUARY, 1923 NO. 2

HOSPITAL STANDARDIZATION SERIES

REPORT OF HOSPITAL CONFERENCE HELD AT BOSTON, OCTOBER 23, 1922

AMERICAN COLLEGE OF SURGEONS
40 EAST ERIE STREET :: :: CHICAGO

CONTENTS

Report of the Hospital Conference Held at the Clinical Congress of American College of Surgeons, Boston, October 23, 1922

MORNING SESSION

AFTERNOON SESSION—ROUND TABLE CONFERENCE

Conducted by Malcolm T. MacEachern, M.D., C.M., Vancouver

REPORT OF THE HOSPITAL CONFERENCE HELD AT THE CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS, BOSTON, OCTOBER 23, 1922

MORNING SESSION—THE PRESIDENT, JOHN B. DEAVER, M.D., PRESIDING

REPORT OF THE STANDARDIZATION ACTIVITIES OF THE COLLEGE IN 1922

BY FRANKLIN H. MARTIN, M.D., CHICAGO
Director-General, American College of Surgeons

IN presenting the fifth annual report of the American College of Surgeons, covering the survey of the civilian general hospitals of the United States and Canada, I have great pleasure in announcing substantial progress in the survey and continued enthusiasm in the work on the part of the profession of medicine, of hospital executives, and of the people.

This stupendous task, the responsibility of which at the beginning was assumed with reluctance by the American College of Surgeons, involving as it did not only the formulation of a practicable minimum standard, but also a continental survey of hospitals to ascertain how many of them already conformed to or were willing to bring themselves to conform to that standard, has now progressed so far beyond the experimental stage that the undertaking has not only been justified, but the responsibility for the continuance of the work for the betterment of hospitals is definitely fixed upon the American College of Surgeons.

The suggestion of a minimum standard was the most important of the initial tasks of the College. Briefly, it included the following fundamental requirements: (1) That the hospital staff be organized and comprised of honest and efficient legalized practitioners of medicine; (*a*) that the staff adopt definite rules for the guidance of its work; (*b*) that the staff meet at least once a month to review the work done by its members in the hospital during the previous month; (2) that accurate and complete case records be written for all patients and filed in the hospital; (3) that clinical laboratory facilities be available for the study, diagnosis, and treatment of patients.

This survey has been conducted through personal visits to the hospitals of the continent by trained medical men who have been specially drilled for this important work. The actual survey was begun in 1918, after much preliminary organization work. The 678 hospitals of 100 or more beds in the United States and Canada were the first to be surveyed, and the reports of 1918, 1919, 1920, and 1921 were exclusively concerned with the 100-bed hospitals. The surveys during 1921 and 1922 included also the 50-bed hospitals.

Therefore, the report that is presented herewith and which covers the 1922 survey, includes both the usual annual report on the hospitals of 100 or more beds and the first annual report on the hospitals having from 50 to 100 beds.

A summary of the results of the reports for the five years is as follows:

In 1918, of the institutions having 100 or more beds, 89 were found to meet the standard; in 1919, 198 fulfilled the requirements; in 1920, 407, or 57 per cent, met the standard; in 1921 the number of approved hospitals grew to 579, or 76 per cent; and this year 677, or 83 per cent, of the 812 hundred-bed general hospitals are on the approved list.

Of the 811 general hospitals having a capacity of between 50 and 100 beds, 342, or 42 per cent, are approved, an excellent showing in view of the fact that previous lists published by the College have not included these smaller institutions.

Grouping together the 1623 general hospitals having 50 or more beds, there are 1019, or 63 per cent meeting the requirements of the standard.

In closing, I wish to state that the American College of Surgeons realizes, inasmuch as it assumed the responsibility of suggesting a standard and surveying the hospitals of the North American Continent, that it is definitely obligated to continue the work until all hospitals of the

Western Continent have been given an opportunity to conform with its ideals. This we can do effectively if we continue to have the hearty co-operation of the medical, nursing, and hospital professions, and the public.

Finally, I wish to acknowledge publicly for the first time the enormous aid the College has received for the last four years from the Carnegie Corporation in financing the important program of hospital standardization. Mr. Henry S. Pritchett, the president of the Corporation (who up to the present has modestly requested that we make no public mention of their aid), has now, at my urgent request, allowed me to make this acknowledgment. The program could not have been so rapidly and efficiently carried out without the Corporation's generous yearly gift.

The program of hospital standardization which has become an epoch-making movement in the progress of medical practice, cannot be properly mentioned without giving credit to one or more pioneers who have devoted much enthusiasm and labor to the task. Foremost among these should be mentioned our former director, now Chancellor John G. Bowman of Pittsburgh University, Reverend C. B. Moulinier, S.J., president of the Catholic Hospital Association, and Dr. Malcolm T. MacEachern, director-general of the Victorian Order of Nurses for Canada and president-elect of the American Hospital Association.

THE DOCTOR AND THE HOSPITAL

By FREDERIC A. WASHBURN, M.D., Boston
Director, Massachusetts General Hospital and Massachusetts Charitable Eye and Ear Infirmary

THIS subject may be divided into two parts: (1) the hospital's obligation to the doctor, and (2) the doctor's obligation to the hospital.

1. The hospital's obligation to the doctor includes its obligations (*a*) to its staff, (*b*) to practitioners in general, (*c*) to physicians who send in patients, and (*d*) to medical students and internes.

a. The hospital should treat its staff with courtesy and consideration—it should grant their legitimate requests as far as practicable. It should make them feel that they are the strong right arm of the administration. By proper organization of an executive committee the staff should be made responsible to the trustees for recommendations of professional policies and staff nominations.

b. The hospital and its staff should share with practitioners in general the advantages which accrue to the fortunate individuals who are on the staff. The hospital may place at the service of local physicians the resources of its X-ray, metabolism, cardiological, chemical, and pathological laboratories in so far as it can do so without interfering with its own work.

The hospital may also give courses on certain days a week which may be attended by practitioners of the neighborhood. Here in Boston such courses have been very successful and much appreciated. They have been chiefly a comparison of clinical and pathological findings with a demonstration of pathological material. Leaders in this work have been Drs. William H. Smith, Oscar Richardson, and Richard C. Cabot.

The general practitioner always has patients with obscure maladies for whom he needs consultation and advice. He wants laboratory and X-ray examinations and, perhaps, the opinion of several specialists. For the rich, these things are provided by admission to private wards and hospitals and in the offices and laboratories of specialists. The poor have the wards and out-patient departments of our general hospitals.

The Massachusetts General Hospital has tried to provide a clinic of consultation for people of small means. Twice a week in the afternoon this clinic is held. Representatives of all professional departments are present. A small fee is charged. The money goes to the doctors after the hospital has been reimbursed for its extra expense for this clinic. Patients are admitted only upon recommendation of a physician. A report of findings is sent him at the conclusion of the examinations. It may be necessary for the patient to come a number of times but no second charge is made. Small laboratory fees are necessary. The patient is referred back to the physician. No treatment is given. The hospital has received repeated assurances from physicians using this clinic that it has been of great help to them in their treatment of patients of small means. The physicians upon the staff have given freely of their services to this clinic. The recompense is meagre but they have felt that they owed this service to their fellow practitioners less fortunate than they in hospital affiliations.

Service to the physician on a broader scale may be exemplified by the case records published by

the Massachusetts General Hospital and edited by Drs. Richard C. Cabot and Hugh Cabot. This publication is sent throughout the civilized world and is of benefit not only to physicians who have access to hospitals, but to many an isolated practitioner in the remote wilderness.

c. How can the hospital help the physicians who send patients to it? The administration must see to it that all inquiries and applications are treated with courtesy. The admitting officer must try to put himself in the place of the harassed doctor at the other end of the telephone. He cannot grant all requests, but he can and must show the hospital's desire to co-operate.

After the patient is admitted, there are many courtesies that the hospital can show the physician who referred the patient. The physician should be notified by telephone of the time of operation. If the patient dies and an autopsy has been granted, the physician should be notified when it will take place.

Upon discharge of the patient, a letter may be written to the doctor giving a brief summary of the case, discharge diagnosis and, perhaps, suggestions for future treatment.

When a physician has referred a patient to the out-patient department a letter should be sent to him stating the diagnosis, and if he is sufficiently interested to make further inquiry, an abstract of record or other information should be sent him without charge. All this involves considerable expense and much work but it is an obligation to the physicians sending patients to the hospital. The institution is amply repaid by the kindly feeling thus gained for it.

d. The obligation of the hospital to its internes and medical students includes their education and training. This is so essential a part of a hospital's duty that I need only name it. The hospital must be sure that its internes receive at least a fair equivalent for the time and labor they give. Careful instruction should be given them and every effort made to see that they get the most possible from their service. The hospital will be repaid by the improved character of house officers and by the possession of fine loyal alumni.

There will be found few today to question the value of teaching to a hospital. It means keen, alert work in diagnosis and treatment. Fortunate is the hospital which has it.

We must see to it that students receive under proper restrictions every facility to acquire knowledge. It is best to make them as far as possible a part of the machine. This is the hospital's obligation to the medical student—the doctor of the future.

2. The second phase of this subject deals with the duty of the doctor to the hospital. By the very nature of his work the physician is an individualist. He works by himself or with a few others. He does not rub shoulders with the masses of men as does the business man. He is the autocrat of the sick room and if a surgeon, he is commander of the operating team. Hence, to work in the organization with many others is difficult for him and team work of the hospital staff is necessary if results are to be obtained.

The successful doctor meets with something like worship from his patients, especially the women and perhaps from his house officers, medical students, and nurses. Under these conditions we sometimes find a surgeon loses his sense of proportion. If he has not a well developed sense of humor he may even take for fact the estimate of him made by these youthful and exuberant partisans. Such a fault brings its own retribution. No one suffers like the vain man. He continually sees slights of his own importance and is always in trouble because of them.

Physicians do not take kindly to discipline. This is because they are individualists. I have known members of the staff to defy authority and state publicly that they would do certain things in spite of the well considered regulations laid down by the executive committee of the staff, trustees, or the director. Such action, of course, can only result in the confusion and humiliation of the perpetrator.

Speaking roughly or rudely to nurses has in the past been a habit with some men, particularly surgeons in the stress of an operation. If a man appreciated how it reacts against his own reputation we should soon hear no more of it.

I have known members of the staff to speak of the administration of the hospital in a disrespectful manner before house officers, nurses, or students. This cannot be ignored, for from it grows insubordination and contempt of authority.

With all their faults I wish to record my belief that among the physicians of a community you will find the highest ideals, the most generous motives, and the kindest and fairest treatment of their fellowmen of any group, bar none. In the two hospitals of which I have the good fortune to be director, I have met with the most cordial co-operation from the staffs. The team work has been good. The faults which I mention have been met only occasionally.

The physician appointed upon a hospital staff has an obligation to give adequate time and the best service that is in him to the hospital. He draws good from his service only in proportion to

the work he puts into it. A hospital service should mean to a man the opportunity to perfect himself in his profession. If he is a surgeon, he becomes manually expert and improves his surgical judgment. If he is a physician, he sees many more patients at the hospital than he would outside and thus his clinical experience broadens. He comes into contact with other keen minds, and slovenly work is not likely to be tolerated. Service to his fellowman is expected of every physician worthy of the name. The profession is not yet seriously tainted with commercialism. The member of a hospital staff has an opportunity to do much good for humanity. This may be in the actual care of patients, laboratory or research work, and the wise counsel or loyal support of those who are trying to make the hospital a success. Members of a hospital staff who are using their position simply for their own financial gain, or to increase their prestige, are of no use to the institution and should be driven from its sheltering arms.

The present hospitals of the country are in a transition period of staff organization. We have always known that between members of the staff of equal ability a man's value to the hospital is determined by the time, work, and thought which he gives to the hospital. As the complexity of methods of diagnosis have increased and as the difficulty of keeping in touch with others' progress increases,—not to speak of making progress for oneself—it has become more and more difficult for the busy practitioner to be on the hospital staff and give the hospital the sort of service required today. From this fact has developed the full-time or paid part-time hospital physician and surgeon. This is a development in the right direction because it gives to the hospital time, work, and thought and continuity of planning and effort which the busy practitioner can never give it. On the other hand, I wish to record my firm belief that the hospital will always need on its staff for the direct care of its patients, men who earn their living in the practice of medicine and surgery; but only such men will be needed by the hospital as are willing to make a very definite monetary sacrifice so that they may give it an abundance of time. Such a man should take his reward in his increased prestige, the fact that this connection makes him a better physician or surgeon, and in the satisfaction of forwarding the interests of the leading factor for good in our modern civilization —the great hospital of the community. The legitimate line of progress in the future would appear to be that all important professional services will be headed by men paid by the hospital for a large part of their time; that under them will be a group of paid men whose time is devoted to considerable extent in teaching and research; but that working with these men and with their rights zealously guarded by the hospital will be the unpaid practitioner who is willing to devote considerable time to the hospital work.

It is an unfortunate fact that there are physicians in considerable numbers who have never received the requisite training, but who are trying to do surgery. To many of our people a hospital is a hospital and any doctor is a surgeon. A way must be found to protect these people. There should be some recognized mark of the competent surgeon and the trustees of all hospitals could then forbid others to operate in their institutions. The private commercial hospital would probably require state regulation.

A hospital must have autopsies if it is to check up the cause of its failures. The family physician can help the hospital there more than anyone else, and in aiding the hospital he adds to his own information.

It sometimes happens that the wrong diagnosis is made or the wrong treatment undertaken at the hospital. The hospital would be helped if the physician would send the patient back or write a letter calling attention to the error as it becomes clear.

In general, we may fairly say that if a hospital is doing its full duty, there will be no difficulty about its receiving the loyal support of the physicians of the community.

Without a good professional staff composed of able, unselfish men, a good hospital is impossible. Without a good hospital, correct medical teaching, progress in medical science, and good care of the sick cannot be had.

We should, then, support the work of the American College of Surgeons which is making a notable contribution toward better surgeons, better staffs, and better hospitals.

THE MINIMUM STANDARD AND ITS APPLICATION TO HOSPITALS

By FREDERICK W. SLOBE, M.D., Chicago
Hospital Standardization Department, American College of Surgeons

DURING the past decade an increasing attempt toward standardization in all fields of human endeavor has been apparent. At first, in certain respects, standardization in medical and hospital activities did not keep pace with its development in other lines. The American College of Surgeons, in its hospital standardization campaign, endeavored to correct this shortcoming. The application of the minimum standard to hospitals, in essence, means the closest correlation of all medical and hospital efforts, and the highest degree of mutual co-operation between each individual associated directly or indirectly with hospitals.

Personal contact furnishes the best index to the application of this standard. Our hospital surveyors, during personal visits to 1600 of the general hospitals in the United States and Canada, have had certain observations impressed upon them so repeatedly that a brief enumeration of these impressions seems warranted.

The staff situation involves so many angles that it is difficult to approach it in so short a space of time. There is no standard type of staff organization applicable to all hospitals. Local variations demand varied types of organization, hence it is for each hospital to decide which type best meets its individual needs. There should be, however, a definite organization, including the formation of sufficient committees to cover the various activities of the hospital, in order that responsibility for these activities be accurately centralized. In this connection, the greatest difficulty exists in the small hospital in the small community, where the entire medical personnel of the community use the hospital. In such instances, it may be wise in the beginning to include on the hospital staff all the ethical practitioners in the community, all of them being expected to attend the staff meetings and to co-operate with the hospital in its efforts to improve. Later, various modifications and improvements in the staff organization may be instituted. A too radical or partisan arrangement of the staff in the beginning may definitely retard the subsequent development of the organization.

Another difficulty exists in hospitals which have a large list of so-called "courtesy" staff members in addition to their "regular" staff. These physicians, who utilize the hospital only occasionally, are often less interested in its progress. Even though they use the hospital at infrequent intervals, they should be expected to live up to all the obligations which the hospital expects of its regular staff. The "courtesy" staff members should be informed at frequent intervals concerning the requirements of the hospital, that they are a part of the hospital so long as they send any of their patients there, and that they are expected to attend the staff meetings.

The analysis of hospital results is one of the chief objectives of the standardization program. Much confusion still exists concerning methods in which this should be brought about; naturally, the same method may not be applicable in all hospitals. The College features the regular monthly staff conference because it is the means by which the analysis is best undertaken in the vast majority of hospitals. It is indispensable in nearly all institutions; in only a small percentage can it be considered impractical, notably hospitals with a staff of only one or two physicians where a formal conference is, of course, out of the question. Whether departmental conferences or combined meetings are held is immaterial so long as the various activities of the hospital are covered.

Teaching hospitals closely affiliated with medical schools and certain group clinics connected with hospitals may undertake thorough analysis in other ways; the former by a presentation of patients before students and the latter by a close association of the physicians. Even in such institutions, however, there is no question but that there are many occurrences of great clinical importance which lose much of their educational value by failure of being brought to the attention of the entire staff. The group clinic, therefore, should have a regular résumé of its results brought before its staff. The hospital of only two or three physicians should conduct a similar, though more informal review, and the teaching hospital may well bear in mind the added impetus which an analysis of this kind may bring about.

It is the feeling of the College that a large part of the monthly staff meeting should be devoted to an analysis of the casualties including the deaths, infections, complications, unimproved cases and in fact, anything closely related to the clinical work in the hospital. The discussion is impersonal, being a study of certain results and the relationship of those results to the hospital. An

attempt at humiliation should not be countenanced; a clear, straightforward, educational discussion, however, will not invoke antagonism. Our failures are the greatest assets in the light of our experience if we only face them squarely.

Hospitals with a large list of "courtesy" staff members have difficulty in deciding whom they should expect to attend the meetings. Many hospitals solve the problem by inviting all to attend but *requiring* the attendance of those who have had patients in the hospital during the preceding month. Some physicians with multiple staff appointments object to the staff meetings, stating that too many of their evenings are thus occupied. It is uncommon to find many physicians who are extremely active in more than two or three hospitals and they should be willing to devote two or three evenings a month to their hospital affiliations. If they are connected with many other hospitals, it is usually in a consulting or relatively inactive capacity which would not require regular attendance.

Relative to case records, the hospital is the logical repository for the medical history of a community. Physicians' office records often are so meagre and varied that they cannot be depended upon to supply complete information in time of need.

If hospitals have deficient records in spite of a sufficient number of internes, it is due to the fact that the internes are not performing their duties because of lack of supervision on the part of the administrative and professional staffs. The available number of internes is insufficient to supply the demand, hence, record clerks or historians are needed. Some hospitals which have only a part-time historian fail to realize the many functions of a case record department. In the future every hospital of twenty-five or more beds will have at least one full-time record clerk. At present many hospitals find it satisfactory to utilize part of the historian's time in other activities of the hospital.

In the cities a not uncommon difficulty exists in certain hospitals used almost exclusively by physicians who have studied their patients thoroughly in their offices, have had a large volume of diagnostic work performed outside, and bring the patients to the hospital for operation or treatment only, failing to realize the necessity for furnishing the hospital with the records. Such physicians often keep good office records; if so, the hospital should be sent copies; if not, the physician should co-operate with the efforts of the hospital to secure accurate records for its files.

A very common deficiency in hospitals which have recently instituted record systems is a very brief, stereotyped form of case record which seems to fit about 80 per cent of the patients and gives one very little knowledge of the diagnosis. In most instances this is due to lack of staff supervision of the internes, record clerks, and of the records themselves. Operation records are notably weak in a complete description of the exploratory findings and operative technique. In order to insure accuracy they should be dictated or recorded during or immediately after all operations. Each physician is responsible for the record of his patient even though most of the labor may be relegated to an interne or record clerk. If so, the physician should take sufficient time to insure the accuracy of the records. This will save him subsequent embarrassment, and will insure the patient and the hospital accurate reports for future reference.

Sufficient space for the record room, conveniently located, must be available; in order to be used frequently and accurately, records must be immediately accessible. This means good filing cabinets and cross indices for name and disease. Whether filed in groups by disease, or filed numerically is immaterial so long as the record can be obtained immediately. There is no standard disease nomenclature which is used by all hospitals. At the present time, therefore, the *International Classification of Diseases*, published by the Bureau of Census, Department of Commerce, Washington, D.C., and other well known disease nomenclatures are being utilized.

Another great omission in hospitals consists in failing to make adequate use of the records. After expending a great amount of time and money on the records, it is a great economic as well as an educational loss if records are not utilized to the fullest extent. By using the records, I refer chiefly to the analysis of hospital results mentioned in connection with the staff meeting and with the work of the record and program committees. After a hospital has a complete record department, material of great statistical value will become available to an increasing extent each year. This will be particularly true when hospitals adopt more uniform nomenclatures so that their statistics are uniformly comparable.

The question of laboratory service involves varied interpretations according to the size, type, and location of the hospital. Each hospital should have a laboratory of its own for the performance of the usual routine examinations, such as various chemical, microscopic, and bacteriological analyses. Naturally, the more technical tests may have to be performed outside as the available number

of serologists and pathologists is not sufficient to supply each hospital. This applies especially to the hospitals in the small communities, in which the service is considered satisfactory if an adequate number of specimens is sent to competent laboratories.

Technicians should have adequate supervision either by a part-time pathologist who visits the hospital at regular intervals, or by some staff member, fully versed in laboratory technique and interpretations. Some hospitals with the most complete laboratory equipment perform fewer tests per patient than hospitals with relatively meagre equipment. Laboratory service, therefore, is not always proportionate to the laboratory facilities themselves. This discrepancy is often due to the system of laboratory charges and affects particularly private patients where a separate charge is made for each test performed. There is often a hesitancy on the part of the physicians to prescribe certain laboratory tests if they realize that a separate charge will be made each time. This can be obviated first by the adoption of a flat-rate fee, to include the usual laboratory examination, or no fee at all may be charged if the cost of the laboratory is determined and subdivided by adding a certain charge to each room or rate per day. The hospital then can insist upon a certain laboratory routine without adding each item to the patient's bill. Tissue examinations must be included in this, in order that the hospital may have every specimen sent to the laboratory. This should be as rigid a part of the operating room technique as the sterilization of instruments. As many specimens as possible should be sectioned, and every specimen should have at least a gross pathological report.

In addition to the almost universal routine urinalysis, however, the routine hæmoglobin estimate and leucocyte count are becoming increasingly prevalent. These, in addition to a routine examination of tissue, serve as a good basis for a minimal, routine laboratory requirement. Physicians should be encouraged to a more routine use of laboratory facilities in the hospital.

In roentgenological laboratories, the problem of adequate interpretation is a serious one, as there is an insufficient number of trained roentgenologists to supply the demand. Here also the question of supervising the X-ray technician is important. A roentgenologist should be in charge of each X-ray laboratory, even though he spends only a few hours each day there for the interpretations. The responsibility of these interpretations should be in the hands of one man, a trained roentgenologist. If left to the various physicians, the patients will not get uniform X-ray service.

The principles of the minimum standard have been adopted by over four-fifths of the general hospitals on this continent. A progressive improvement in hospitals is everywhere apparent; but there is need for a closer insight into the real meaning of these principles. Let us hope, therefore, that each hospital superintendent, each member of a board of trustees, and each physician will see more clearly his individual obligation and responsibility and that the increased co-operation resulting therefrom will bring about a fuller realization of the spirit embodied in the application of [illegible]

WHAT REAL AND LASTING BENEFIT HAS COME TO THE PATIENT FROM HOSPITAL STANDARDIZATION?

[illegible] CHARLES H. MOULINIER, S. J. [illegible]

THIS is a rather presumptive topic for a layman to have chosen and yet it is only a variation of the theme I have been talking on to medical men and hospital people ever since I have been associated with the American College of Surgeons in its program for standardization.

We must understand standardization thoroughly and deeply in order that we may appreciate whether or not it is anything real and of lasting benefit to the patient. Standardization is an external means of making things in the hospital and the work of the medical, nursing, and hospital professions more or less uniform. It is laying down rules for the conduct of the hospital, for the conduct of meetings of the staff, for the making of records and for the equipment, manning, and using of the laboratories. It is inevitable that any form of standardization should aim at some kind of uniformity. What I shall say to you grows out of my experience with the College and my observations of the great body of Catholic hospitals in charge of Sisters, some 674 on this continent, with something like half the bed capacity of all the general hospitals, and also out of the observations I have been able to make in regard to other hospitals.

This external standardization is accomplishing great things. The number of hospitals that have been put on the College's approved list is growing rapidly. All this indicates an eagerness on the part of the medical profession and of the hospital people to be on that desired list. However, it is not being on the list, it is not being surveyed and pronounced by the surveyor as fit for the list, that makes the hospital an actual agency to give every patient that which the standardization program has purposed. We all know that the aim of the standardization movement of the American College of Surgeons is to benefit the patient, but it is not going to benefit the patient, no matter what external form of standardization may be brought into the institution, until the medical profession, the nursing profession, and the hospital people actually and physiologically function as a unified institution for the purpose of helping each particular patient.

This movement is bringing about a closer coordination of laboratory and clinical medicine. The movement is making the medical man a better diagnostician and improving the results in all fields of medical practice. As fast as human nature will permit, it is obliterating the distinction between laboratory and clinical medicine. It is focusing the mind of the managing personnel of hospitals upon the importance and the fundamental character of diagnosis, and as the diagnostic ability of the surgeon, the internist, and the pathologist improves, of course the patient is benefited. As a result, the medical mind is becoming more thoughtful, more anxious, and more reserved in its diagnosis, the surgical mind is holding back surgical therapy until the diagnosis is as clear and sure as modern medical knowledge will enable it to be, and I believe that the number of operations is being reduced, and that those which are performed are done with greater skill, with greater caution, and with more finished technique, with the men performing them more thoughtful, more careful, and more conscientious. If this be true, that the surgeons are really lessening their work and improving the work that they do, what a credit, what an honor it is to the American College of Surgeons for having instituted such a movement. What a credit and honor for all those other bodies which are gradually coming to realize that this movement of the College is a genuine one, a scientific one, an unselfish one; one that is bringing to the patient what the patient had a right to—the best scientific, the most conscientious, and the most highly human service that the medical, nursing, and hospital professions are capable of giving.

Is there still room for more of these higher qualities of science, training, and care to be interjected into the so-called standardization movement? By all means. The defects of the profession of the present are just along the very lines which standardization emphasizes: organization, records, and laboratory service. The medical mind is an individualistic, scientific mind. But that does not mean that it may not be a get-together mind; that it may not be a more conscientious group mind; and that it may not be a more hearty and lofty character which puts aside all those selfish, petty, individualistic characters which are not a credit to the individuality or to the profession.

I am going to venture to say to you that the medical profession today is a profession greater in character, has developed greater individuals, is at least in its solidarity as a profession more conscientious than it was five years ago when this movement began, and is working closer with the nursing profession and with the hospital authorities than it ever did before. They are working in the open daylight; they are working with one another. The day when an individual doctor could do as he might be prompted to do and take a patient to operation without careful, considerate diagnosis and operate as he pleased with closed doors is practically gone. It exists here and there. Therefore that first essential of the College, organization, necessarily brings about the association of all those concerned with the patient so closely that individual weaknesses, individual limitations, and individual pettiness are bound to disappear.

The case record is one of the elements which is making the medical profession more careful and more thoughtful and here, also, lies one of the greatest needs for improvement. You cannot leave the making of the record to an interne, to a secretary, or to a historian. You can ask them to help you and wherever they can they should help you, but the final balancing of the facts into a safe, scientific diagnosis must come from the trained medical mind alone; and the older and better trained that medical mind is, the better. Until every one of the medical profession realizes this and is willing to assume the difficult task of being back of the record, just as he is back of the therapy that follows, the sooner will this wonderful standardization movement mean more for the patient in real and lasting benefit.

THE AMERICAN HOSPITAL

[illegible]

ONE particular hospital may seem to be a comparatively fixed and established organization, but the American hospital as a national program of public service is a rapidly changing institution. This paper aims to place before you a few comments on present drifts, trends, or policies from angles other than the usual professional viewpoint.

Conceptions of the hospital as a form of charity and as an organized assistance to physicians in their work are now quite *passé*. The progressive hospital aims to be a factor in the public health and the medical service of the community and to make a positive contribution to the future medical and health status of the nation.

But the penalty for activity is responsibility. Just now the American hospital is in the process of finding out the responsibilities it has assumed by asserting itself and assuming an independent identity. The information is coming through Supreme Court decisions, through public demands and expectations, from the just appeals of the leaders in medical, nursing, and social service professions and from the findings in public health studies. Without question a greater responsibility to humanity, to the political state, and to the individual patient has been assumed and must be met. This does not imply any lessened or even modified personal responsibility of the physicians practicing in the hospital; rather it is new and distinct.

The American hospital, and this means a larger group than the university or teaching institutions, is assuming direct and full responsibility for the professional care of patients. No other interpretation can be placed on the admission of a ward patient. The hospital contracts to furnish the professional as well as the accessory service. The right to assume such a contract and to execute it through professional agents is not questioned. Court decisions are now quite generally (Massachusetts is, however, an exception) holding the hospital responsible for the patient to the extent of the exercising of due and proper care in the selection of agents, specifying as such "physicians, nurses and other attendants." The arguments assert that the hospital can and should know as to the competence of these agents, but it can not follow their every act.

In several cases personal damages have been collected by patients from hospitals, causing more uneasiness than is justified. The decisions are based on only two points: first, the universal principle that the hospital, as all individuals, must be just before it be generous; and second, that due and reasonable care must be exercised in the selection of agents. To this much the public clearly is entitled. This uneasiness will not affect good hospitals and will (as it should do) make poor hospitals better.

Attention is also attracted to the fact that the recent court decisions are pointedly neglecting any consideration of such points as whether the patient in question was free, part-pay, or full-pay, whether a ward or private patient, or how the medical attendant was selected. They seem to assume that the hospital acted as a responsible principal in a public service capacity and that all who ministered to the patient while in the hospital were its agents.

The proposal that hospitals revert back to the policy of assuming to give only bed, board, and accessory care was not long ago given wide publicity, but it brought no response other than condemnation. The American hospital is to stay a medical institution and face its assumed responsibilities.

All this makes the formulation of any standard, however limited in scope, of great value to the field. The hospitals were slow to recognize the value and benefit to them from the formulation and urging of the minimum standard by the American College of Surgeons. At first the standard seemed too closely restricted to the professional activities. All of it does deal directly with professional conduct, but as the professional responsibility of the hospital became better understood and accepted, the application and value of the minimum standard became more thoroughly realized. The Catholic Hospital Association first gave it support. Later the American Hospital Association officially endorsed it without reservation, and today it has our unqualified support. Any hospital not meeting this standard now keeps still about it, for it has become a measuring stick of recognized units.

That the specimen removed at operation belongs to the hospital and not the patient or surgeon has become an established principle and practically universal practice. But do we yet fully realize the obligations and responsibilities

this places on the hospital? The leading motive behind the establishment of this decision was, of course, the protection of the hospital. But ownership of the specimen cannot fail to carry with it the responsibility to use it for the benefit of the patient, for the promotion of public health, and for the progress of the medical sciences. All this is in harmony with the development of the hospital as a responsible medical institution and a part of it, yet these responsibilities are so often neglected. Laboratories and medical research are not maintained entirely for the patient, for the staff or the student—they are essential to the hospital in the proper meeting of its assumed responsibilities.

In one policy the American hospital seems to be fixed. This policy is its allegiance to the cause of scientific medicine. There has been no wavering. Last year the legislatures of several states passed bills requiring that any hospital in order to claim tax exemption must admit the patients of any person licensed by the state to practice any form or any part of the healing art and under the full control of such persons. None of these was signed by a Governor or became a law. There will be more of these bills this year to fight, but fight them we will. The sustained verdicts against hospitals have become the protectors of hospitals. If the Supreme Court of a state holds the hospital responsible for the exercising of due and reasonable care in the selection of its agents, specifying physicians as agents, hospitals must be granted the right to select these agents, the right to appoint a staff and the right to decide who may and who may not treat patients within the institution.

The organized staff requirement of the minimum standard has the universal support of the hospital groups and the indorsement of all the progressive elements of the medical profession. It is also in harmony with court decisions and principles established thereby. It must be about right.

HOSPITAL STANDARDIZATION FROM A PUBLIC HEALTH STANDPOINT

By D. A. CRAIG, M.D., Chicago
Associate Director, American College of Surgeons

THE basic principle of all our public health work is the prolongation of human life and the increasing of human efficiency. Consequently, no public health work can hope to attain the maximum of success which does not have in co-operation with it the medical profession and our hospitals. You might as well try to run a railway without a department of repair and a department of research as to run a public health campaign without a hospital. You might as well try to run a railway without engines and without engineers as to work for public health without the co-operation of the medical profession and those of us interested in hospitals. There has been expressed in several parts of this continent the idea that we as a medical profession and we as hospital people are not interested in public health; that we are only interested in people who are sick so that we can make money out of them. It is up to us as members of the medical profession to prove to the public that we are interested in public health not simply by showing or saying that we will do this or that but by taking the leadership in public health and by proving to our people that we are interested in it and are willing not only to co-operate but also to be leaders in the great movements for public health, better health, better hospitals, and for better public service on the part of our medical profession. Every human being, whether he likes it or does not, is an asset or a liability in the community in which he lives. And our hospitals should return to each community, for the community investment, dividends in restored human efficiency and economic value.

I sometimes wonder if we should not sit down and consider whether our hospital this year has returned a sufficient dividend; whether in our hospital we have done all we could to see that those dividends were the highest possible, to see that we have done better this year than last. And now, if you do not remember anything else that I may say to you this morning, there is one thing I want you to remember, and that is this: *Our hospitals owe to future generations records of present experiences.* I want you to take that home with you, put it in the record room of your own hospital and in your own office, and remember that we owe to future generations records of present experiences.

Do you ever realize that we recognize the old masters today by the records they have left behind them? All our medical knowledge has been based upon records of the past and surely we will go on with that structure, building upon firm foundations for future generations to benefit by and build upon further. Now, whether you have recognized it or not, we have never realized before

how essential records are to a hospital and it is up to us to go home after these meetings, with a little more enthusiasm and interest, and to insist that we have as good hospital records as we can have, so that we will lay the foundation for the future, and future generations will bless us because we have given them the records of our present experiences.

We sometimes hear people say that the modern health ideas are all a fad and folly and that this hospital standardization program is just a fad of this American College of Surgeons. They may not see in it the move for better public health on the part of the medical profession and those interested in hospitals. To those people who would object I will say this, there is absolutely no use in throwing bricks at the sunrise for the dawn will come just the same. We have in this hospital standardization program a wonderful opportunity for public service. In our hospitals we have an opportunity to teach health and to take a part in the great campaign for health education, getting people willing to be healthy. You cannot legislate a man to be healthy, but you can teach him to be healthy.

In some of our textbooks we have chapters on anatomy and physiology, and the little folks do not know what they mean. We do not care whether the child thinks his stomach is in his body or not provided he knows when to eat, how to eat, and what to eat. And that is the kind of information we are trying to put over in our hospitals and we seek to prove to people in this country that we are interested in public health and that we are interested in their welfare, in attempting to prevent human illness and to prolong human life.

Now, let me ask you to put your enthusiasm into it, put your muscle into it, put your backbone into it, and realize that this program means a tremendous amount not only to you personally but to the community in which you live. Spread your enthusiasm to everybody in your hospital, even to the board of trustees, so that your hospital will be better this year than last, and that you will have a stronger influence in the community in which you live.

SIDELIGHTS ON HOSPITAL STANDARDIZATION

BY MR. ROBERT JOLLY, [illegible]
Superintendent, Baptist Hospital

I DO not know why I was given the subject of "Sidelights," but I would say that the important lights that I come in contact with in the hospital are these:

First, the lamp light represented by the patients, whose lights are flickering and dim and nearly ready to go out.

Another light in the hospital is the incandescent light, in other words, the folks who help to make the hospital go. Day and night, twenty-four hours, straight running, these lights are burning, in the operating room, delivery room, laboratory, history room, and everywhere. They do not make much noise, and they are not very large, but they are always active and ready.

The directors I would liken to arc lights. They are the big lights but they usually hang about outside. They are fine to have around but they do not shine but half the time. Out on the street when things get dark, the arc lights are turned on. So it is in a hospital; when things get dark and stormy we call on the directors and they begin to function.

The other light is the searchlight and you men of the medical profession are the searchlights. You keep prying around into places and asking questions. You search out the history of the patient before operation; you search out the patients themselves and you search again after operation. You are searching and re-searching all the time and we cannot get along without you.

I believe the greatest single factor for the protection of the patient is the minimum standard evolved by the American College of Surgeons. It is the testimony of hundreds of hospitals everywhere that it has been the greatest stimulus toward better service and closer co-operation among the factors in the running of a hospital that has ever been known.

Without co-operation it is impossible to run a hospital. I would say that the man upon whose shoulders falls most heavily the task of eliciting co-operation is the superintendent. I think I can best illustrate his position by my hand. Consider the thumb as the superintendent of the hospital. Consider my first finger as the patient, the second finger as the staff, the third finger as the board of directors, and the fourth finger as the associates of the superintendent. You will readily see that the superintendent's task is not only to co-operate with each of these four groups but to get each of these four groups to co-operate with the others.

perience, the minimum standard has been an inestimable help in doing this very thing. When a patient comes into the hospital he is likely to object to his history being taken or to the pathologist making his laboratory test. But when it is explained to him that he is in a standardized hospital and that, for his own protection, it is necessary to make these tests before he is operated upon or before any treatment starts, he usually sees the wisdom of it and begins to pride himself upon the fact that he came to a recognized hospital.

Sometimes the patient objects to a flat-rate charge for laboratory work, contending, many times, that a patient ought to be charged for just what he has received instead of an equalized rate for everyone. When they come to me about this I remind them that two of them get on a street car and pay the seven-cent fare. One of them rides three blocks and the other rides three miles; yet both are contented and do not dispute with the street car company. That usually satisfies them.

The minimum standard has already wrought wonders in the staff work of the hospitals. In many hospitals before the standard was set up, the staff meetings amounted merely to a social gathering where nothing of any real value was done and where the meeting usually broke up with wrangling. Now, however, the men know that in order to keep the hospital up to the standard, they must do a definite work at their monthly meetings, must go over the records of the hospital, and that man who has had a mortality among his patients must explain why. They also have found that each man, instead of being a star, is one of a team, and that he can count on all of his fellow workers to give him their best judgment. And so they have learned to work together.

In our own hospital, the staff has recently sent an invitation to the superintendent of the hospital, the superintendent of nurses, and their supervisors to meet with them each month for the first thirty minutes to go over ways and means for increasing the efficiency of the hospital. Not only that, but they have appointed an efficiency committee which meets with an efficiency committee of the board of directors to seek suggestions for the betterment of the hospital.

New light has come to many boards of directors as they have found that the minimum standard is something to be proud of. It is amusing but gratifying to go to many places and see the directors priding themselves on the fact that they now have a standard hospital. They have now learned that they are more than a finance committee and that they are absolutely responsible for everything that goes on in that hospital. They have found, too, that it makes a vast difference who operates on patients and that an operation is not the first resort, but the last. Since they are finding this out they are a thousand times more careful about who to put on the staff, for, if their hospital has already attained the minimum standard, they do not want to drop back and, if they have not attained it, they are putting forth every effort to do so.

The hospital superintendents over the country are finding that the spirit of the standard is getting into the hearts of their associates in management. When questions arise they are now being solved in the light of the minimum standard. In our own hospital we have a weekly council of all those in the employ of the hospital. We never have a meeting but that some question arises and in trying to solve it somebody will say, "Now, remember the minimum standard says so and so, and we must be careful about that."

I find that associates in hospitals are taking a great deal more care to explain to the patients and to the visitors the "why" of the records and the laboratory work and other things that are made necessary by the standard. They go to great pains to explain to patients coming from outside that we cannot allow just anybody to come in and operate for we must vouch for the work done by every man operating in the hospital.

So I say that the minimum standard is not only arousing enthusiasm in each one of these groups and giving them a new vision of hospital work, but it is bringing them to a point where they cooperate better than at any time in the past.

We must use as much sense in running a hospital as the large corporations are using today. We are grateful that so many hospitals of 100-bed and 50-bed capacity have already attained the minimum standard and we are looking forward to the not far distant day when all of them can hit the mark and then the standard will be raised a little higher and we will all go after that.

THE ANALYSIS OF END RESULTS

Joint Discussion

By EUGENE H. POOL, M.D., New York

Dr. Eugene H. Pool: By end-result we mean the ultimate outcome in operative cases in respect to general health, symptomatic relief, anatomical condition of the parts affected, and economic efficiency of the patient, especially the period and degree of his disability.

By analysis of end-results is meant primarily the grouping and study of the results in types of cases and operations.

To obtain these facts a system is essential entailing some labor and expense. The natural query is whether the results justify such outlay. Let us first outline some of the advantages of an end-result system and analysis and then describe the details of a system by which end-results are obtained: an answer to the query may then be obtained by balancing the credit and debit columns.

Advantages Accruing from an Analysis of End-Results

The patient. Early and regular observation and examination of patients often results in timely and prophylactic advice as well as the early recognition and correction of failures or complications. Take, for example, an incipient hernia in an appendiceal wound. Such incisional hernias if left to the patient's impulse, often become large and difficult to close before advice is sought, whereas timely repair is extremely simple and reliable. Again, early recognition of a recurrence in carcinoma at times affords the possibility of prolonging life and comfort. Such types, which could be multiplied almost indefinitely, are met with extensively in the routine examinations of a follow-up clinic. The patients not only profit greatly but appreciate the interest shown, as is evidenced by the regularity of their visits.

The surgeon. The knowledge of the results of types of operations and the amenability or resistance of various lesions to surgical efforts is of inestimable value to the surgeon. The most effective, far-reaching instruction is derived from the grouping and analysis of an accumulated mass of these cases. The failures are often disheartening because exact figures give to the failures a far more conspicuous place and a far higher percentage than is derived from impressions. Memory is not relied upon and convenient forgetfulness is impossible. Yet such truths stimulate the conscientious worker and show him his weaknesses. His work from year to year as a result becomes more reliable and careful, his usefulness being proportionately increased. We will mention two groups which have been studied on the Second Surgical Division of the New York Hospital.

Hernia. The analysis by Dr. Seward Erdman of a series of 1000 consecutive inguinal hernia operations has occupied a period of about five years. Eighty-nine and five-tenths per cent of the total operations were adequately traced. The number of return visits and examinations averaged 2½ for each case and ranged from three months to seven years.

The analysis has brought out many interesting facts. For instance, recurrences are 6.67 per cent; in oblique hernia, 3.15 per cent; and in direct hernia, 16.61 per cent. The time of recurrence in about half was within six months, 98.6 per cent recurring within two years after operation. Therefore, it is shown that a hernia which has not recurred within two years after operation can be regarded as a cure. Recurrences in patients over 55 years of age were found so high that operation is not considered advisable unless there are strong indications.

In cases of non-descended testicle treated by the Bevan method, the testicle remained in the upper third of scrotum in 80 per cent, and remained atrophic in 55 per cent.

The vast majority of hernias recur in their original type, that is, direct as direct and oblique as oblique. A direct recurrence after an oblique operation usually indicates oversight of a saddle-bag sac at the primary operation.

Hysterectomy. Dr. E. M. Hawks[1] followed and analyzed 84 cases of hysterectomy to determine: (1) what benefit was derived from leaving the ovaries, and (2) what harm resulted from leaving them. He demonstrated that: (1) the onset of vasomotor disturbances was delayed and the severity of the symptoms diminished by leaving one or preferably both ovaries; (2) very little harm was caused by a retained ovary (one cyst required secondary operation; one patient

experienced persistent pain referable to the retained ovary); (3) there was more trouble when the tube was removed than when it was left with the ovary. A number of similar analyses have been made.

Science of medicine. That these studies are not laboratory or experimental in nature have removed them from the attractive realm occupied by pure research, but such information and study estimated in the uplift of surgery might be fairly balanced with most of the results which reward the time-consuming efforts of the average research worker and should be subordinate only to epoch-making additions to scientific knowledge. But for such work materially to affect surgery as a whole it will be necessary to weld together the findings in many institutions, thus obtaining figures of convincing magnitude, and likewise to compare results of various institutions, some of which will afford standards to be striven for by all. To attain this ideal, the general adoption of a follow-up system is essential and likewise a somewhat uniform method for recording the results so that those of various services can be readily balanced or co-ordinated.

To summarize: The surgeon becomes more proficient; as surgery improves, the community is benefited by curtailment of economic waste; the institution profits in respect to turn-over; patients present and prospective, for whom on last analysis all efforts are directed, profit greatly.

THE SYSTEM EMPLOYED

The necessary factors are: One clerk for an average service of about 100 beds; card system; social service; follow-up clinic; collocation and analysis of mass results by special workers.

In regard to the clerk the only feature to emphasize is that the volunteer worker is inappropriate and salary is therefore necessary. The social service department is an essential part of every hospital and either exists or should at once be installed in every institution. Its follow-up work is a detail, not the reason for its existence. It is used to pursue such cases as resist summons by card. In 1921, after seven years' experience with the follow-up work we followed 95.7 per cent of all post-operative cases. Seventy-seven and seven-tenths per cent reported in person; in 20 per cent of the total the social service was called upon for help. They obtained information concerning 88 per cent of those referred to them. The card system is of necessity complicated but is quickly mastered by the clerk. Various systems have been published and need not be reviewed. They do not differ in essentials.

The follow-up clinic is the most essential feature but is likewise the stumbling block. We find a weekly Sunday morning clinic best, since the working classes are free and prefer to come then instead of at night after a day's work. The staff alternate so that no attending is on duty two successive Sundays. Two of the attending staff, three of the house staff, and one nurse serve each Sunday from 10 to 12. Regular attendance with enthusiasm and kindness in the work is the difficult factor to perpetuate week after week, year after year. It is this feature which has resulted in the breakdown of such systems as have failed.

The grouping and analysis of results should be carried out by the allotment of subjects to men on the staff and outside workers who are interested in special subjects. A system by which summaries of all important types of cases may be kept up-to-date is not difficult to carry out, and such analyses should be published.

To summarize, the advantages of end-result analyses are overwhelming and incontrovertible; the expense insignificant; the labor considerable but worth while. The factors which have militated against the general adoption and continuance of such an obviously good system are the frailty of human endeavor, often called staying power, and the lack of anything individual and effulgent in the results. For the system demands team play, not individualism, and depressing failures and disappointments rather than adulation and successes are the outstanding and yet useful elements in the analyses of the follow-up clinic.

DR. E. A. CODMAN: Seven years ago the Clinical Congress of Surgeons met here in Boston. At that time the Committee on Hospital Standardization presented a report recommending a classification of hospitals into two divisions: (1) those which make an effort to find out what kind of results they are getting, and (2) those which do not. During these seven years the American College of Surgeons has made great efforts and spent many thousands of dollars on a far more complicated plan.

It is an unpopular task to criticize this movement of so-called standardization of hospitals now that everybody is doing it, just as it was an unpopular task to cry aloud to have it done. With all that we have heard and read about hospital standardization, could we today really make a preliminary classification into those which analyze their results and those which do not? Are there not still marble halls in the approved list of the College where the individual patient is only

"material," and in which analysis of the results is ignored?

Unquestionably this standardization program has helped many a hospital to raise money for laboratories and equipment. It can be made to appeal to the bankers and idle-rich of any community. The ideas expressed in the minimum standard appeal to practical common sense and reach the lay audience; undoubtedly money has been raised thereby. But has the essential idea of analyzing the end-results *in order to improve on them* been lost sight of? If today we went back to the suggestion of seven years ago and classified hospitals into those which care to follow up and analyze their end-results and those which do not, I fear we should find a much smaller approved list than we now have.

Real analysis of end-results means too much hospital "shake-up" to be taken too seriously. "All is not gold that glitters." The successful practitioner of medicine or surgery is still an accomplished diplomat and it is such men who still control the policies of most hospitals. The public benefactor is not yet ready to listen to the efficient, studious analyzer of results, but has the greatest respect for the cheerful and wise practitioner whose good common sense "saved" his baby "from having pneumonia," or who kept his neurasthenic wife from knowing the baby had pneumonia until after all danger was over.

After all, for whose interest is it to analyze end-results? Of course, the patient, medical science, and that abstract entity "the hospital" would all benefit. But no one can deny that the staff would earn less, would work harder, and would feel themselves bridled and harnessed with the trustees holding the reins. So, too, in the case of the trustees there would be more trouble. They would be obliged to hold the reins gently but firmly, on these newly harnessed horses. It would be far easier for them to leave the horses to feed themselves out in pasture as at present. They might employ a first-class hospital superintendent as coachman who would make the horses comfortable and contented and ready to prance when he cracked the whip; but even then it would be more trouble for the trustees, for they would have to watch the coachman as well as the horses. And as for the coachman, where is the ambitious hospital superintendent who wishes to drive a staff and be responsible for keeping them well groomed and contented! Most hospital superintendents rather have the animals out in pasture.

So, though it appears certain that the patients, medical science, and each hospital would be benefited by an end-result analysis of all cases, it is also true that staff, superintendent, and trustees would all be temporarily the losers.

There is a peculiar personality in a hospital called, "They"; "They" ought to do this and "They" ought to do that. It is this "They" who ought to analyze the end-results. "They" should discharge the incompetent; "They" should promote the efficient. In your hospital who is "They"? In most hospitals, I fancy "They" are utterly intangible and are usually friends of the trustees who hold positions on the staff, and who work confidentially with influential members of the trustees, rather than through the regular channels of staff meetings. "They" as a rule do not wish for searching end-result analyses. One seldom wishes for a thunderstorm for it may strike near home, and yet, if it is inevitable, we take it calmly enough.

The end-result system is something like a thunderstorm. It is an unwished-for hospital guest. It is blown on us by the winds of progress and is inevitable. Let us accept it, since we have to, with the best grace we can. Even if we in this generation treat it as evasively as we do prohibition, let us accept it for the next generation; but let us make it a staff policy and not make it necessary for the trustees to drive or to hire a coachman. Let us take the joy of the fire-engine horses to have the harness on our backs and "run with the old machine."

FUNDAMENTAL PRINCIPLES INTERPRETED FROM THE HOSPITAL STANDARDIZATION PROGRAM

By MALCOLM T. MacEACHERN, M.D., C.M., Vancouver

I AM going to summarize with lantern slides the fundamental principles and results of hospital standardization. (*Illustrated with lantern slides*)

1. *Organization*—organization of the professional group in the hospital is effected, thus tending to stimulate better organization throughout the other groups working therein.

2. *Ethics*—a higher type of ethics among the professional group is developed which reacts beneficially, not only on the internes and nursing staff, but also on the patient and fellow members

of the profession by an inherent desire and habit to practice medicine honestly.

3. *Self-government*—a system of self-government is established among the professional group which today is recognized as a type fruitful of best results.

4. *Efficiency*—efficiency in all professional work carried on in the hospital is demanded and this reacts in a stimulating manner on the general efficiency of the entire institution.

5. *Co-operation*—a spirit of co-operation is promoted—a fundamental principle for success throughout the hospital which primarily affects the medical group and rapidly embraces all others concerned in the welfare of the institution.

6. *Investigation*—investigation of all matters pertaining to the professional work in the hospital, whether good or bad in quality, is required so that an intelligent balance sheet of results of treatment can be obtained.

7. *Regularity*—regularity in staff procedure by meeting at regular intervals is made imperative.

8. *Helpfulness*—the fact that the program is one of helpfulness to the weaker members of the profession is always emphasized, demonstrating that it is inclusive rather than exclusive in its scope.

9. *Communalism*—a spirit of communalism is stimulated among the medical men working in the hospital and this is much needed today.

10. *Consultation*—the habit of consultation between individuals or groups of the medical profession is promoted, thus reacting beneficially, not only for the patients concerned, but for the stimulating of clinical interest and the advancement of medical science.

11. *Check-up or audit*—a careful check-up or audit of all the medical work is demanded to determine the net results of the application of medical science in the institution.

12. *Cohesion*—better cohesion is secured among the individual members of the medical profession practicing in the hospital through staff organization and staff conferences, which materially stimulate and strengthen the local, state, provincial, and national organization of medicine, all of which is so much needed today to promote health and scientific medicine, as well as to rid the country of the quack.

13. *Accuracy and thoroughness*—accuracy and thoroughness of work is demanded by careful study of the cases to make a correct diagnosis, thus applying more intelligent and competent treatment ultimately to produce the best possible results.

14. *Confirmation*—the doctor is provided with facilities for confirmation of findings through human or physical methods of investigation.

15. *Research*—a spirit of research is developed through the stimulus of clinical interest as well as the greater availability of accurate scientific data which otherwise might be passed over or not discovered if the method of procedure laid down by standardization was not carried out.

16. *Conscience*—a more profound professional conscience in the hospital is established.

17. *Hospital perspective, objective, or focusing point*—the fact that the patient must be the perspective, objective, or focusing point of all hospital services is emphasized.

By means of the monthly analysis or audit the hospital can prepare a practical, business-like summary of its results. A suggested form follows:

PHYSICAL BALANCE SHEET

Physical Report of Hospital for month of August, 1922.

(A) Volume of work:
Admitted — Died
Discharged — Remaining
Transferred

(B) Physical Assets:
Cured — Improved

(C) Physical Liabilities:
Unimproved — Infected
Complicated — Died

(D) Net Results—Physical Surplus or Deficit.

Certified correct and all details thereof duly investigated by the Medical Staff of the Hospital, this...day of....., 192..

(Signed)_____
Chairman of Staff.

(Signed)_____
Secretary of Staff.

To summarize, this standardization campaign has amply demonstrated a definite economic saving in addition to the well recognized improvement in professional care. This may be expressed in the following manner:

Net Physical Results of Hospital Standardization

1. Lessened days' stay of patients in hospitals;
2. Elimination of incompetent and unnecessary surgery;
3. Reduced number of complications and infections;
4. Lower hospital death rate.

AFTERNOON SESSION—ROUND TABLE CONFERENCE

CONDUCTED BY MALCOLM T. MACEACHERN, M.D., C.M., VANCOUVER

SECTION A—STAFF ORGANIZATION

BY FRANK D. JENNINGS, M.D., BROOKLYN

THE topics for discussion under staff organization are divided into six questions. I will take up these questions separately:

1. Because of the different varieties of hospitals and because of the number of doctors attending, in certain instances difficulties often arise in the selecting of the exact type of staff organization best suited to local needs and conditions. Are there any guiding principles that would help in this matter?

Taking hospital conditions on the average throughout the country, there are three types of hospitals: the closed, restricted, and open types. The closed hospital is generally a well organized institution, and may be dismissed this afternoon with just that reference. We will best serve the interests of this discussion by thinking of hospitals with either "restricted" or "open" staffs. In the East I think the restricted hospital is more common than the open and the converse is true in the Middle West and the far West.

Now, the restricted hospital, which is the type of hospital that I am connected with in Brooklyn, is administered somewhat in this fashion and I believe that if I recount to you that method of organization it will simplify the discussion.

There is, first of all, a board of trustees, lay and ecclesiastic, under which is a medical board composed of the attending staff members in the various services. The medical board is charged with a fixed and definite responsibility for the medical and surgical care of the patients entering the hospital. All the details, all the other subdivisions of the hospital, function under the medical board, the interne staff, the nursing staff, the dispensary staff, and the courtesy staff. The courtesy staff is composed of men to whom are extended the privilege of caring for private patients in the hospital, and the character of the courtesy staff frequently, too frequently, determines the standards and standing of the hospital. The men of our courtesy staff are appointed after recommendation by two members of the medical board, and after approval by the whole board they are nominated by the board of managers. The appointments are for one year. This is a simple but efficient organization.

The board of trustees says to the medical board, "Take care of the medical and surgical affairs of this institution and account to us."

Now, an open hospital is perhaps different, but the underlying principle is just the same because it simply means organization. It means getting those men who compose the professional staff of that hospital together in an organization, which need not be complicated, the simpler the better, with a constitution and by-laws.

2. One of the ultimate objects of hospital standardization is to promote a more constructive professional interest in the hospital by the doctors attending. To this end is it advisable to make more or less division of professional responsibility by dividing the staff into representative committees to look after various phases of the work, as for instance: medical committee, surgical committee, laboratory committee, records committee, etc.?

An efficient organization cannot operate successfully in any other way. A chamber of commerce, a rotary club, a large banking institution, or any large mercantile organization will function that way, and we do not differ in any sense. We are charged with the solemn responsibility of caring for sick people. That necessitates organization and it means as good an organization as we can construct. Referring again to my own hospital and the experience that we have had there, I may say that we have found that we need an executive committee. It is obvious that there must be some committee representing the medical board between meetings. It consists of the president and secretary of the medical board and one member-elect.

Secondly, the most important, is an efficiency committee. Only within the last year have we reorganized our system of distribution of work through committees.

Medical groups do not differ essentially from other groups. Some men will work, some will not. We had a committee on internes, committee on laboratory, committee on operating room, and so on. The chairmen used to work but the other members of the committees did not. It occurred to us that it would be very much more sensible to

combine in one committee all the functions that had been distributed in a large number of committees; so we appointed an efficiency committee composed of a chairman and four members. To one man is assigned internes, another the nurse training school, another the laboratories, including the diet kitchen, and another the operating rooms. The chairman exercises general supervision, presides at committee meetings, and correlates the work of the committee.

This committee has functioned beautifully. It has simplified the work because, assuming that committees are composed of three or four, we can get five men in a hospital group who will be active, efficient, and interested, where we cannot get fifteen or twenty. Now you will notice that this combines what I may term the intramural activities of the hospital. The dispensary committee is a separate committee and properly so, as its work is extramural. The efficiency committee does not include one extramural phase. The staff conference committee, because its work is so important and essential, combining as it does the necessity for arranging the monthly program for staff meetings and in addition the supervision and care of the records throughout the hospital, was made a separate committee.

3. Many hospitals, and especially those without a medical superintendent, are at a loss to know how to initiate staff organization and staff conferences. How best can these be initiated?

The way to initiate is to *initiate*. What advice can be laid down that will supply the professional staff the stimulus to do this thing if that professional staff lacks the interest, lacks the determination, lacks the will to do it? That is what counts. If your staff is right you do not have to initiate organization because the staff will do it and the staff will see the inherent necessity and inherent good. Suppose the French at Verdun had said, "We hope they will not pass." What might have happened? What did they say? They said, "They shall not pass." There was a concrete illustration of national determination of a thing that had to be done. And in a small matter it is the same.

4. The staff conference to be a success must have certain agenda on its program and definite lines of procedure. What, therefore, is the best type of agenda and method of procedure for such a conference so as to obtain the best results?

This is a broad question, difficult to answer, but taking the average hospital conditions throughout the country, in perfecting your staff organization perhaps the first thing you should do is to make the records better. That was our situation; our records were very bad; we found at the beginning that the type of conference devoted to mortality discussion was the most practicable, the most satisfactory, the most stimulating, and in the end the best, for it not alone created a condition whereby a man had to face his mortality but it made him more careful of his record. It has been of remarkable interest through these years to see the records come from conditions of absolute oblivion up to a fair degree of perfection. So that in the average general hospital at the beginning the mortality type of conference is the best.

Going on from that you come to the time when it begins to lose its interest. The records have come up nearly to par and your staff review analysis at the end of each month may not show more than fifteen or sixteen incomplete records in a month as against eighty or one hundred before. Then, perhaps, comes the consideration of morbidity and, in the last analysis, the staff review. So that I should say that the agenda should consist of, first, the staff monthly review; second, mortality; third, morbidity, and then the staff analysis or study of the staff work in that hospital. Not what somebody is doing in Vienna, not what somebody is doing in other cities, but your own staff review of its own work. That is the best.

5. Many staff conferences in hospitals today are poorly attended, evidently due to lack of interest and enthusiasm. What are some of the methods being used for stimulating interest and enthusiasm in staff conferences?

A good staff conference committee and a good program is all you need. If you have the right kind of committee and right kind of chairman with initiative and energy and the right instinct, you do not have to worry about the program. They are up to the mark all the time. Staff review opens up a field as wide as medicine. Take a review of hernias, for instance. We heard something about it this morning from one of the surgeons in New York, which shows what staff review means, and it is to the credit of that hospital and that surgeon that he publicly proclaimed the results. It is healthy, helpful, and honest. Without honesty in your staff nothing else counts.

6. Hospital standardization recommends and requires an analysis of the work during the previous month or period. What should this analysis contain and who should prepare it or present it?

We believe that it should be prepared in the record room. It is our custom that it be written

on a large blackboard and it is the first order of business taken up at a staff conference. It comprises the total number of admissions, the total number of discharges, the mortality, the number of operations, both in general surgery and special branches of surgery, the number of laboratory examinations, and the number of ambulance calls; in brief, it is a statistical study of the work of that hospital for the month and the chairman usually devotes a few minutes to its consideration, which is very stimulating. The whole thing simmers down, it seems to me, to honesty of purpose and to earnestness. We heard this morning concerning the five lights of hospital standardization. Well, there is a sixth light, and that is the light that is ahead of us all the time—the goal that we are aiming at—good hospitals and good work.

DISCUSSION

Dr. Walter E. Lambert, New York: Dr. Jennings said there is first of all a board of trustees with the medical board subject entirely to the trustees' orders; that the medical board is given the authority to conduct the medical work of the hospital. What authority has the medical board in the general conduct of the hospital and are there any medical men, members of the staff, who are members of the board of trustees? That is a very serious question which we all recognize.

Dr. H. Wellington Yates, Detroit: May I ask the essayist to discuss for us the question of mortality in relation to the monthly staff review and the staff meeting? Should these matters be discussed freely before all the physicians present and should there be a free discussion and criticism of the results obtained by various staff members?

Dr. Edward W. Mulligan, Rochester, New York: We have as high as 70 per cent attendance all the time. The men in the hospital who do the best work are always in attendance. We take up the mortality every Sunday from 12 to 1 o'clock but make it short and bring in as many patients as we can. It is at the monthly meeting that we take care of the work which you are discussing here. Is this a good thing to do? Is it a better way to do it at the Sunday meeting or is the monthly meeting better? Are we doing something that the rest are not doing? Is this weekly meeting attended by all the members of the staff, a better thing to do than to have monthly meetings alone?

Dr. Southgate Leigh, Norfolk: Infection occurs entirely too frequently, even in the work of the best operators, and in high class hospitals. This is due to several causes, such as inattention to surgical cleanliness because of its extreme simplicity, multiplicity of operators, etc., but chiefly, I believe, to the fact that but few hospitals have the proper staff control of the operating department.

Years ago in each principal hospital there was usually one dominant figure in the surgical department, who ruled the department by force of superiority and high standing, and whose hobby was the operating room and its detailed direction and control. Today in each hospital there are several high class surgeons, all standing practically on the same footing. The management of the operating rooms, however, is suffering. What is everybody's business is nobody's. Some hospitals have already recognized the danger of the situation and have appointed in each a staff operating room committee, but rarely with the proper authority.

What is needed is this: that member of the staff who is an enthusiast on the vital subject of surgical cleanliness should be selected and put in charge of the operating department and he should be given sufficient authority to control every detail of its management. The operating room nurses and assistants should be constantly under his supervision and direction, and in a judicious manner he should make such simple rules as may be necessary for the guidance of the surgical staff.

This is an exceedingly important matter for which I would ask the earnest consideration of the College. Time permits me only to mention the principle of the plan without considering its many and weighty details.

Dr. Frank D. Jennings, Brooklyn: Answering Dr. Lambert, his question, as I understand it, involves medical representation on the board of trustees. Our medical board is not represented on the board of trustees. Our board is lay and ecclesiastic but not medical. It seems to me that under average conditions lay control gives about as satisfactory a result as any. I presume you have seen, as I have, medical politics in hospitals and other places, and while perhaps lay boards may at times go astray, my feeling is that in the end average justice is done just as well by a lay board as by a medical board or a board with medical representation. I do believe that perhaps one medical representative would be good. I know of one hospital in Brooklyn which has that type of organization and I believe it has functioned very well. We get around it in this way: our board of trustees designates one man as executive member; he is the link between the board of trustees and the medical board. He meets with the executive committee of the medical board which is composed

of three, making a small committee which functions ... and avoids much lost motion.

Replying to Dr. Yates, I believe there should be a frank discussion which is the practical way in which this program works. I do not see any reason why any member of the staff who has operated on a patient who died subsequently should not stand up frankly to answer any question that any member of that staff may ask as to why he did that thing or why he did not do it. This, it seems to me, is the essence of the whole proposition. But we go further; we have a little reading stand on the platform with a light overhead so that it casts its effulgence right over him.

Answering another query, we include morbidity and I believe that it should be included. This is a review of the work of the staff. We have had very striking examples of morbidity, perhaps embarrassing to the man involved but very illuminating and helpful to us all.

In answer to Dr. Mulligan, I think they are very fortunate in his hospital in being able to have such a satisfactory attendance each week. We have thought of it because often with a conference held once a month the work of a given month, particularly between November and March, may be too extensive for one meeting and we have considered whether it would be a good proposition to meet weekly. I still feel that with the multiplicity of meetings that a medical man has to attend we would do better in many instances by adhering to the monthly meetings. In many of the larger hospitals they have departmental conferences once a week but they take into consideration only their own departmental work. But the monthly meeting goes along for the whole staff. I think there is a field for the weekly service conference and indeed a field for the conference you hold and you are fortunate in doing it so successfully.

SECTION B—CASE RECORDS

By GEORGE A. RAMSEY, M.D., and ROY C. KINGSWOOD, M.D., London, Ontario

DR. GEORGE A. RAMSEY: A hospital may be described as a public utility filling a position of need. As such, its function is to give efficient service. In that service, how do records function?

The patient has the priority of claim and has the right to expect such thoroughness as is included in an effective record. The physician fulfills a duty to himself in giving to the patient such study of the diseased condition as is outlined in a record. The public, whose institution the hospital is, has a right to feel secure that the procedure therein is thorough, painstaking, and logical, in order that conservation of life may add to the community asset.

The institution needs to know that it is discharging its full duty to the community through its staff and officers to the end that efficient service may become its tradition in perpetuity.

These are axioms and it is with their application we are concerned. Records are financial, social, and medical. With these last I propose to deal.

While mindful always of the requirements of the standards set by the American College of Surgeons, I want to warn against records kept merely as so much manuscript with no attempt at application. Likewise would I add my protest at any attempt to make the hospital fit the record, and not the record to blend with the character of the hospital.

In arriving at what might serve Victoria Hospital, London, we made an analytical examination of at least thirty sets of hospital forms and chose what seemed most applicable to a municipal hospital of 400 beds for public and private patients, comprising the whole series of types of service, selecting what seemed to meet our particular needs, discarding much and here and there contributing some little thing that appeared to warrant a trial.

There was an effort made to link in harmonious union with hospital records those documents required in dispensary and follow-up social service. We had the satisfaction afterward of seeing almost an identical system described for a hospital that compared with ours in size and service.

The requirement which guided the adoption of any form was that it should be simple in legend and complete in the outline which should guide the investigator, leaving always scope for individuality. I protest against such efforts toward standardization as would stamp out individuality. Again, in the interests of economy, time, and money, we endeavored to secure such procedure as would make every single effort at record, from admittance slip to discharge certificate, a constant working tool and a permanent document. It is easy to carry system to such a degree that it enslaves. Re-duplication may weary and discourage even the most energetic.

The end purpose of a record is a diagnosis, demanding complete, prolonged, and detailed study of the patient from physical, mental, and psychological viewpoints. In this evolution of analysis the record should always be a guide to investigation, an adding machine of daily and hourly observations to the ultimate totalization of a diagnosis of the patient, not alone of his disease; and it does not stop there. Treatment follows on the conception of the cause, course, and expected outcome of the condition and is varied to meet its changing phases. If, then, it gives proof of intelligent endeavor, it deserves to be history; and if it fails, simple honesty likewise requires a record of what has been tried and found wanting.

I wish to quote Dr. Emerson's definition of a record: "It is not our imagination or our memory of past events but a painstaking entry on imperishable human documents of what is at the same time the glory and the humility of medicine, the truth as we see it, when we see it, the facts as our faltering and unskilled senses take note of it, whether in the immediate presence of suffering humanity, or at the operating or autopsy table, while still the echo of the laboratory test is knocking at our conscience. The present is ours to record. Tomorrow it belongs to the past."

Father Moulinier very strikingly has given the following definition: "Records are facts that you find, that you filter, that you focus, and then face fearlessly."

I wish to acknowledge the pioneer work of the late Dr. J. L. Stapleton in laying the foundations of our record system in Victoria Hospital, London. This was carried on by Dr. J. R. N. Childs, and I acknowledge gratefully also the sympathetic support of trustees, staff, internes, and record clerks in making the effort possible.

We have a few slides to show the cogs in the machine of our system of records following which Dr. Kingswood will demonstrate their workings.

Dr. Roy C. Kingswood (remarks illustrated by stereopticon slides): Dr. Ramsey has given you the machinery necessary for a carefully designed hospital record system. We shall now attempt to show how easily this machinery works at Victoria Hospital, London, Canada, after it has been carefully oiled and lubricated. Even the minor manufacturing concerns have men in their employ to whom they pay substantial salaries, who do nothing else but check and record the materials, cost results, and other data concerning their manufactured product. If business men deem it necessary to exercise so much care in the record of the process of manufacture of their article, how much more careful should be the medical men who are attempting to repair the human body so that a definite record should be kept of the attempt at repair while in the repair shop, namely, the hospital. Also how essential it is to the patient that a repair record should be kept for any necessary future reference. We thought our method would be best explained if we were to take an actual case and follow it through the hospital from the time of admission until discharge.

Slide 1. Mr. John Doe enters the hospital on July 1. The necessary notification has been given to the attending physician and interne. The interne visits the patient, not with a huge pad of record papers in one hand and a fountain pen in the other, but purely to meet the patient and become acquainted with him, make sure that his wants are being supplied and to find out the nature of his case. This gives the interne his approach to the patient and then a short while later he is able to obtain a history which is a real record of the patient's condition. The history embodies, first, the present complaints, second, the onset and course, and third, the previous illnesses and family history.

Slide 2.—Physical examination. The interne then proceeds to the physical examination which we require to be complete and if there are any findings in his examination which are not absolutely clear we require that he consult one of the senior men. Perhaps the two most important notations on this form are: first, the working diagnosis (after physical examination). We require that the interne write down his provisional diagnosis after he has summed up the case and that he adhere to this diagnosis until someone who knows more about the case proves that he is wrong. In this way he gets his training and is encouraged to think. Second, the signature of the staff physician. This proves to the interne that the visiting physician has been sufficiently interested in his work to read what he has written.

Slide 3.—Progress notes. This is a record of the patient's general condition, post-operative course, and condition of the wound and includes the opinion of any doctor who may have been called in consultation. We require that these be written at least every three days.

Slide 4.—Operative record. This is a concise, detailed record of the procedure and findings at the time of operation. Dictation is carefully given by the surgeon or senior assisting interne immediately after the operation.

Slide 5.—X-ray report. A report from the de-

the chart. A miniature reprint of the plate accompanies each report.

Slide 6. —Laboratory findings. The laboratory findings are recorded as seen and include urinalysis, blood, serological, and other reports. The interne is responsible for much of the laboratory technique.

Slide 7.—Temperature chart. The patient's temperature, pulse, and respirations are kept as above; also a record of the number of stools, urinations, and other similar data.

Slide 8.—Nurse's record. A record made by the nurse of the patient's general condition, medication, treatment, and doctor's visits, and other associated notations.

Too much cannot be said for the nurse who carefully records the condition of the patient, as she sees the patient oftener than the doctor.

Slide 9.—Dental record. To make our record complete we have a post-operative record of dental examination and any extraction, prophylaxis, etc., done at the dental clinic.

Slide 10.—Chart folder. On the discharge of the patient, the interne is responsible for checking the chart to make sure that all the records are complete. It is then placed in the above envelope, properly filled in and the discharge diagnosis completed and presented at the record office for the approval and signature of the director of records.

Now just a word as to how we obtain these records.

Slide 11.—Internes on wards taking histories. The interne has tried to win the confidence of the patient by his gentlemanly and professional approach.

Slide 12.—Internes making physical examination. We require that a nurse be present at the examination of all female patients and that the patient be draped in such a manner as to insure a careful examination and yet not offend the delicacy of the patient. In this way we have no trouble with our private patients.

Slide 13.—Convenient place to write records. This plate shows a sun parlor adjacent to a ward where the internes may write their histories without being disturbed; many discussions of the various cases take place here.

Slide 14.—Record office. One corner of the record office showing an interne dictating a history just completed and the other interne giving the operating room report immediately following an operation.

Slide 15.—Group of internes on the surgical service analyzing the records of all cases of carcinoma of the breast admitted in 1921 with the idea of publishing their results. This leads to staff conference analysis and promotion of scientific research.

Slide 16.—Operating room scene. This patient had a laparotomy performed two years ago and probably just as important a factor as the proper technique of opening the abdomen is the previous operating room report to show what pathology was found at that time. The interne is reading this former report in detail.

Slide 17.—Cost of chart system. The cost of our system is 51½ cents per patient per year.

Is it not worth while from your standpoint, fellow practitioners, to know that a complete record of your patient is being kept while in the repair shop? Is it not your duty to make sure that these records are written for your patients wherever you may send them—even if you have to write them yourself? And you who may be patients in the repair shop—do you not consider for your sake that these records should be kept?

SECTION ON CLINICAL LABORATORIES

By JOHN F. BRESNAHAN, M.D., Bridgeport, Connecticut
Superintendent, Bridgeport Hospital

THE following questions have been assigned to me in the discussion of this subject:

1. In some hospitals today there are very fine laboratories capable of doing all the services necessary, but not much used by the medical staff. What methods can be employed to stimulate increased use of such laboratories by the staff?

In a great many hospitals one finds the laboratory located either in the basement or in some part of the grounds other than in the main hospital. The pathologist is present in his own little department but does not come in contact with the patients in the wards. He sometimes, but rarely, leaves the laboratory. The specimens, whether tissues or blood smears, come to him without any connection with the patient whatsoever. He has not seen the patient, and the slip sometimes merely names the part of the anatomy from which the specimen is taken but no other information is given. He gets into the habit of looking at these samples as having no connection with anything else except the container in which they come. He then tries to guard against mistake, and in order to avoid being mistaken he very often will first hedge, and then incline to give an affirmative diagnosis only in case the indications are very marked. The pathologist and roentgenologist should be consultants and when we have our pathologist coming in contact with the patient as consultant, then I think we will clear up that first question. In our hospital the pathological laboratory is a service of consultation, for example, the consultation slip goes to the pathologist, and he sees every patient from whom blood is taken and can give a better opinion on border line reactions than if he never saw the patient.

2. There are various systems used in our hospitals for making laboratory charges; some according to schedule of prices per test or examination, and others by means of a flat rate. In the opinion of many the method used in making laboratory charges has a direct relation to the laboratory service. What, therefore, is the most desirable method to adopt?

The hospital superintendent generally has to face a deficit. When the deficit is a little larger than expected (as it is every year) he has three methods of approach or three methods to solve the problem. First, he attempts to reduce the price of food, and the quality of food is apt to fall. Next, he raises the rates of private rooms; and, next, he inspects the laboratory charge to see how he can split it up and make an extra charge. So that where it used to be a two-dollar flat rate fee they now split it into three or four items of one dollar each. What happens to the patient who comes in with an obscure disease for which a number of laboratory tests are necessary? He is penalized, so to speak, for having an obscure disease, and the number of laboratory tests raises the cost for that patient, which is not right. After all it seems as though the limit for charging patients has been reached. If the laboratory tests necessary for diagnosis are costly, out of proportion to what the patient pays, instead of trying to get the patient to pay more we should go out for a definite campaign either to endow that laboratory or to collect money for the purpose.

In too many hospitals the laboratory charge is gradually increasing. A doctor says: "I would like to order a fluoroscopic examination, but the patient cannot afford to pay for it." Or, "I would like to have that tissue sent away to a reliable laboratory and have it checked up. It does not look like carcinoma, and I would like to be sure of it." But a little extra charge of ten dollars determines the matter in the mind of the doctor as to whether that patient shall have a laboratory examination.

One of the best ways to do it is to have a low flat rate for each patient, say two dollars, and let that include everything and if the laboratory is not self-supporting let us make it s[illegible] ask the patient to pay more.

3. There appears to be no definite information as to the extent to which routine laboratory examinations should be carried out. What is the general opinion in regard to this?

I do not think anybody can answer that question except the staff of the particular hospital involved. It may be a wise thing in some communities to have a routine Wassermann examination of all ward patients and it may be necessary sometimes to make exceptions to that rule but it works out in most cases. I do not think that question is answerable except in particular hospitals where the staff can meet and adopt a routine

procedure which fits that community. One routine procedure can be adopted in the maternity department; when a woman is delivered and the cord is cut, a test tube is held under the cord and part of the blood allowed to run into it. This blood is sent to the laboratory and thus one is able to detect specific disease and start treatment immediately for both the mother and child.

There ought to be no question that a hospital should require at least a urinalysis, hæmoglobin determination, and leucocyte count. To my mind there is no question, in fact, it is absolutely essential that every piece of tissue removed in the operating room should be sent to the laboratory for examination. This examination, at the minimum, should consist of the gross pathology, and a report of the microscopic examination whereever possible.

4. Many small hospitals today have considerable struggle carrying on a laboratory service for their institution, especially when there is no highly trained pathologist or bacteriologist in the community. Many also are anxious to know what facilities should be provided and the extent to which the service should be extended. Therefore, how far should the small hospital go in its laboratory service? What facilities should be afforded and what personnel?

In a small community, especially hospitals in the country, it is sometimes necessary to induce some of the younger men who have had good training, to specialize in laboratory procedure, or to go away and take a course in laboratory technique. Almost any hospital will take as an assistant a young physician who wants special training of this kind. Then he can go back to his own community and supervise what is being done in the laboratory. Specimens which may have to be sent to a city laboratory, for example, can be reported on by telegraph if necessary. If the situation will warrant it the doctor can take one of the nurses in the hospital and show her the routine necessary for simple laboratory procedures, sending specimens requiring highly technical examination to the state laboratory or to a good ethical laboratory under private auspices.

In our own hospital we have two graduate nurses who serve in the laboratory. These nurses have been taught to make the routine blood analysis and other tests. One of these nurses works one week in the laboratory and the other week alternates in taking routine histories in the wards. It works out very well. These young women can be taught the ordinary laboratory procedures and when internes are not available they will be found valuable aids to the hospital laboratory if they are checked up in their work by the pathologist of the hospital, not once a month or once a week, but every day.

SECTION D—ROENTGENOLOGICAL SERVICE

By WILLIAM A. LaFIELD, M.D., Bridgeport, Connecticut

IT has been suggested that our discussion of this subject be limited largely to the extent and supervision of X-ray service in hospitals. Accordingly, our program contains the following questions to guide our discussion:

1. Hospitals today are asking what should constitute a complete service in an X-ray department. Should all institutions be able to perform fluoroscopic examinations, gastro-intestinal work and treatment?

2. In many hospitals today the X-ray department is under the management of trained technicians. It is generally stated that interpretation of X-ray plates can only be done successfully by the trained medical man. In such places as cited, interpretation has to be left to the individual physicians referring cases. Is this satisfactory, and can you have an efficient X-ray service in this manner?

I have great reluctance in coming before you and attempting to give precise answers to some of your problems as to the X-ray laboratory in a small hospital. May I say first a word as to the responsibility of the roentgenologist. In the first place, the responsibility for the service must be left to a competent roentgenologist who must be a graduate physician well versed in anatomy and physiology; he should be a competent physician, so that he may study with you the essential data regarding his X-ray finding and give you an intelligent interpretation. He must have a fair working knowledge of radio-physics. He must be a good amateur photographer, something of an electrician, and something of a politician. The technician—the individual who does the routine work of the laboratory—should be a graduate nurse trained by a roentgenologist and should follow a definite routine technique in all roentgen examinations; and she must work under the supervision of an attending roentgenologist. She must confine her activities entirely

to X-ray practice. She must work under such supervision that she will realize her limitations and responsibilities.

With a hospital of perhaps 100 beds or in a community of 25,000 or 50,000, it is not usual to have a man giving his entire thought and attention to the practice of roentgenology as a profession. A community as small as that will not adequately support a man doing roentgenology as a specialty. In any hospital measuring up to the standard of the American College of Surgeons there is no reason why this department could not be placed under the intelligent supervision of a roentgenologist who is not necessarily an active member of the hospital staff. He may be a man in a comparatively remote place from the hospital he serves. It seems to me the first plan would be to establish a small department under the immediate supervision of a graduate nurse who has been trained in this work.

Perhaps we can best bring out the answer to the first question, "What should constitute a complete service in an X-ray department?" by giving you first the limitation of your roentgen service. There is no doubt in the mind of every man doing extensive work in this line that every hospital should be equipped to do roentgenological examinations of the gastro-intestinal tract, chest, skull, and the urinary tract. Some hospitals leave the entire charge of roentgenology to a technician. Would you rely upon the opinion of an orderly or a nurse for an interpretation of the changes in the renal pelvis? Would you rely upon the opinion of a high school graduate, not a graduate physician, as to the significance of a tuberculous lesion in an extremity? In my mind there is no question as to who should assume the responsibility of X-ray interpretation.

The interpretation of X-ray plates cannot be left to the various members of the hospital staff. The relationship of the roentgenologist to the staff is the relation of the consultant to the physician. If the roentgenological service is to be of any real value in your hospital you must look upon your roentgenologist as a consultant. If the roentgenologist is of the right type his opinion is just as valuable as the opinion of your attending neurologist. In our hospital we do not send a requisition for an X-ray examination; a consultation is arranged and the patient is referred to the X-ray department for consultation. If a medical roentgenologist is in charge of the X-ray department he should be equipped to do roentgen therapy. That is a procedure of such responsibility that it cannot be left to a technician no matter how well trained.

I am in a position to judge somewhat of the X-ray needs of a hospital in a small community, and I believe we have solved the problem for one hospital in our state near Bridgeport. A hospital of about 100 beds in a community of 25,000 has a competent graduate nurse in charge of the roentgenological service and the films that are taken there are sent to us for interpretation. A roentgenologist can in the course of two or three months train a graduate nurse in the roentgen examination of the gastro-intestinal tract so that she can produce a series of plates following out a standard technique. A movement has now been instituted by the American Roentgenological Society to standardize X-ray reports. A long time ago routine examinations were standardized as to technique, and the standardization of the report and the individual interpretation of it will mean adequate service for the small hospital.

I believe that technicians assuming the responsibility in hospital X-ray service should be examined as to their fitness for the work, be registered, and kept within their limitations.

SECTION E—NURSING SERVICE

BY MISS MARY BEARD, Boston
Superintendent, Instructive District Visiting Nurses Association

THE report which I will present is a summary of the nursing survey made by the Rockefeller Foundation and includes the nine conclusions to which the committee came.

This study of nursing education originated in January, 1919, when, due to the fact that the Rockefeller Foundation had been appealed to from so many angles to give gifts to support nursing education in one way or another, it decided that it was advisable and really would help the cause to get together about fifty persons concerned in education and discuss the advisability of making a really thorough scientific study of the whole subject of public health nursing, particularly whether anyone other than a graduate nurse could do this work effectively, and if so what preparation that other woman ought to have. It was the pressing need for more nurses in the field of public health that first suggested the desirability of such an investigation.

The committee states that they have attempted to survey the entire field occupied by the nurse and other related workers of this type, to form a test of the qualifications necessary for their education, and on what basis such a function would be sound economically and conform to educational standards, for which there appears to be a vital social need. The persons constituting the committee as it finally got to work —because almost immediately when we began to study the subject of public health nursing we found it necessary to study the subject of nurses—consisted of doctors and hospital superintendents, the latter including nurses and physicians.

The nine conclusions to which the committee came, it seemed to me, you would want to hear, because they take up the really important and controversial points in the question of education. The conclusions are as follows:

"1. That, since constructive health work and health teaching in families is best done by persons (*a*) capable of giving general health instruction, as distinguished from instruction in any one specialty; and (*b*) capable of rendering bedside care at need; the agent responsible for such constructive health work and health teaching in families should have completed the nurses' training. Experts other than nurses, such as nutrition workers, social workers, occupational therapists, etc., should be called on to perform their special functions, in cooperation with the nurse.

"That as soon as may be practicable all agencies, public or private, employing public health nurses, should require as a prerequisite for employment the basic hospital training, followed by a post-graduate course, including both class work and field work, in public health nursing.

"2. That the career open to young women of high capacity, in public health nursing or in hospital supervision and nursing education, is one of the most attractive fields now open, in its promise of professional success and of rewarding public service; and that every effort should be made to attract such young women into this field.

"3. That for the care of persons suffering from serious and acute disease the safety of the patient, and the responsibility of the medical and nursing professions, demand the maintenance of the standards of educational attainment now generally accepted by the best sentiment of both professions and embodied in the legislation of the more progressive states; and that any attempt to lower these standards would be fraught with real danger to the public.

"4. That steps should be taken through state legislation for the definition and licensure of a subsidiary grade of nursing service, the subsidiary type of worker to serve under practicing physicians in the care of mild, chronic, and convalescent illness and possibly to assist under the direction of the trained nurse in certain phases of hospital and visiting nursing.

"5. That, while training schools for nurses have made remarkable progress, and while the best schools of today in many respects reach a high level of educational attainment, the average hospital training school is not organized on such a basis as to conform to the standards accepted in other educational fields; that the instruction in such schools is frequently casual and uncorrelated; that the educational needs and the health and strength of students is frequently sacrificed to practical hospital exigencies; that such shortcomings are primarily due to the lack of independent endow-

ments for nursing education; that existing educational facilities are on the whole inadequate for the preparation of the high grade of nurses required for the care of serious illness and for service in the fields of public health and nursing education; and that the chief reason for the lack of sufficient recruits, of a high type, to meet such needs lies precisely in the fact that the average hospital training school does not offer a sufficiently attractive avenue of entrance to this field.

"6. That, with the necessary financial support, and under a separate board or training school committee, organized primarily for educational purposes, it is possible with completion of a high school course or its equivalent as a prerequisite, to reduce the fundamental period of hospital training to twenty-eight months and at the same time, by eliminating non-educational routine and organizing the course along the intensive and co-ordinated lines laid down in Miss Goldmark's report, to give a sound and practical training, entirely adequate for the preparation of the type of nurse needed for the care of the acutely ill and for the hygienic education of the public; and that courses of this standard would be reasonably certain to attract students in increasing numbers and of high quality."

That is, in twenty-four months with four months added for preliminary training, if we followed Miss Josephine Goldmark's outline of study and made these twenty-eight months really educational, we should provide a graduate nurse who really would have had experience in mental illness, in communicable disease, in pediatrics, and in nutritional study. It was found in one of the very best hospital training schools that we have in this country, that a process went on which was known as milking the floor of the diet kitchen. That was actually a process of rubbing that floor with milk and it took half an hour a day of the nurse's time, the nurse who was fitted to care for the sick. The milk had a tendency to polish the floor, the custom was established many years ago when the milk supply was plentiful, and few people knew that it was being done!

A Vassar training camp student sent to one of these hospitals to complete her training, was made to do that thing. But she did wish she had more opportunity to find out about the care of sick people. And in another hospital, a registered hospital too, the single lecture which the nurses were to have in nutrition was attended by the investigator, and it was found that it was being given by a man who was an advertising agent for a food preparation. He had asked for the privilege of talking to these girls in training about foods and this was the only lecture they had on nutrition. Those instances you will find in Miss Goldmark's report.

In following her recommendations it will be found that the twenty-four months, with four months extra for preliminary training, are to be given to the study of those things which theoretically we have, but actually and practically too often we do not have.

"7. That the development and strengthening of University Schools of Nursing of a high grade is likely, directly and indirectly, to accomplish more for the improvement of nursing education than any other single step which can be taken at the present time.

"8. That when the licensure of a subsidiary grade of nursing service is provided for, the establishment of training courses in preparation for such service is highly desirable; that such courses should be conducted in special hospitals, in small general hospitals or in separate sections of hospitals where nurses are also trained; and that the course should be of eight or nine months' duration.

"9. That the development of nursing service adequate for the care of the sick and for the conduct of the modern public health campaign demands as an absolute prerequisite the securing of funds for the endowment of nursing education of all types; that it is of primary importance, in this connection, to provide reasonably generous endowments for University Schools of Nursing; and that gifts for this purpose, at the present time, are likely to accomplish greater results in the promotion of the health of the people than those which are offered by any other line of community or philanthropic effort."

DISCUSSION

MRS. WILLIAM LOWELL PUTNAM, Boston, Massachusetts: I have been for many years interested in the training of nurses spoken of in the fourth section of the conclusions. I believe, speaking as one of the public, that the nursing needs of the public are not now being taken care of adequately. The very poor and the very rich are cared for but not the large body of people. If they employ a trained nurse the price is now absolutely beyond their means and they descend to the ranks of the poor. For those people, nurses can be provided of a separate grade and I should be very glad—in fact I will ask any of you who will attend the school for which I speak—to welcome you at the Household Nursing Associa-

tion at 222 Newbury Street. We have for a great many years carried on this work and the attendants whom we graduate have been found entirely satisfactory to everyone employing them. They are given the four months' bedside training in the hospital and two months' training in dietetics, including housework because they supply the need of the sick. They do the housework and care not only for the sick in the home but for the home in the sickness, which is very often what a tired and sick mother wants—to avoid getting up to cook an early breakfast and send the children to school, to find these things taken from her, and to see that the children are sent along to school and the husband with his dinner pail.

We work with a very high grade hospital for our training. In the September report for the summer months, there were fifteen of our students trained at the Memorial Hospital in Gardner, three in the Framingham Hospital, thirteen in other hospitals, and fourteen taking training at their home. The price, of course, is very much less and for chronic cases and cases of mild illness, they are absolutely satisfactory. Take, for example, a maternity case, where the woman is delivered in a hospital. She does not require a trained nurse to take home with her to take care of her baby. The trained nurses are not now taught to do many of the necessities of life for the patient of moderate means. They do not like to wash the baby's diapers, or carry up the breakfast tray. And those things are not a part of the trained nurse's training, and it seems to me, if you will excuse me for saying so, that the fault lies with the medical profession. The medical profession undertake, to their glory, to take care of all classes of people, no matter what their means, and there is nobody in the community who does so much for charity. But they have not socialized the training of nurses as they should.

I was consulted the other day by the State Nurses Association, who wanted to bring in a bill to have a supervisor standardize the training of nurses. They do not want a doctor, they want a nurse. Now the nurse and the social worker are the doctor's right hand, and we are taught on high authority: "Let not your right hand know what your left hand doeth." But there is nothing to prevent letting your brain know what both hands do.

THE RIGHT OF A HOSPITAL TO APPOINT A STAFF

By A. R. WARNER, M.D., Chicago
Executive Secretary, American Hospital Association

THREE factors have caused the current keen and general interest in the question of the right of a hospital to appoint a staff. The inquiry comes from every group interested in hospital work.

1. *The rapid increase in the number of hospitals appointing a medical staff.* The motives behind the appointment of staffs have been primarily to insure the patients of the institution—particularly the free and part-pay cases—a better medical service. It is done secondarily to secure the continuity and the unity of professional policies necessary to develop teaching and also to create an organization which can properly direct and develop the various aids to the professional work maintained by the hospital (as laboratories, etc.). The arguments advanced and points considered have been confined entirely to the internal operation of the institution. The right and duty of the hospital to do this have not been emphasized and established and are, therefore, questioned by objectors.

2. *The organization of those objecting to the existence of the hospital staff, and concerted action by these objectors.* Several state legislatures have passed bills removing from the classification as charitable institutions (tax free) any hospital not admitting to practice in the institution all licensed practitioners of the state. This included not only the regular graduates in medicine but the medical cults as well. The cults have vigorously protested because the existence of a staff and professional policies and standards in hospitals have kept them out. These bills were all vetoed by the Governors but considerable publicity on the question was secured. Objectors in the regular medical profession have been active. One county medical society of Ohio promptly expelled eight of its members who accepted positions on the newly formed staff of the local hospital.

All objectors have questioned the right of the hospital to choose its agents or, as they have expressed it, "to discriminate."

3. *The clearer establishment of a definite liability of the hospital for its patients.* The word "liability" has an ominous sound: it suggests litigation and damages. Hospitals know that their liability has increased and that supreme courts

are confirming damage awards in some cases. Instead of studying their liability and developing plans to meet it, the hospitals generally have shuddered at the very thought, hoping that such a calamity might never come to them and have feared even more the suggestion of a lawsuit. The reaction of the hospital in this frame of mind to the threat of a local practitioner to sue "for his rights" and "for damages if excluded from the institution" is often so feeble and timid as to be pathetic. Sometimes this is not purely bluff on the part of the local practitioner. He really believes that the funds to build and maintain the hospital were given, primarily, to provide facilities to physicians for their personal use and, secondarily, for the welfare of the patients, instead of, primarily, for the welfare of the patients and, secondarily, to the profession as a whole for its development. Every hospital must know the basis of its appeal for funds—whether for the physicians in the community or for the patients in the institution—and the trust assumed in accepting funds to carry out this purpose, is the only obligation. In this they are fully protected and it is the failure to perform this trust to the letter that creates the liability.

These three factors have not only raised the question as to the right of the hospital to appoint the staff but surrounded it with many complications, irrelevant to be sure, but nevertheless confusing. These can be neglected. By "right" is meant legal right. The question as to the advisability of the staff is not a factor other than indirectly through the establishment of the decision that a staff does or does not better the service rendered to the patients in the hospital. The courts would certainly recognize not only the privilege but the obligation upon the trustees of every hospital to provide every reasonable means in their power to improve the professional service rendered by the institution to its patients. This is the trust they have assumed. But all this depends on the interpretation of the value of the staff to the patients. This is not final—therefore not considered here. The final answer to the question is, of course, to be found in the law itself as finally interpreted by the Supreme Court. Let us consider this.

In the decisions of all courts on questions pertaining to the liability of hospitals, two fundamental principles have always appeared. In a way, these principles are irreconcilable. The first principle invariably considered is the protection of the rights of the individual. There never was any question as to the liability to a person injured by a nuisance created by the hospital on its premises and the question always arises as to why patients should be excepted. The second principle invariably considered is the obligation upon the courts to protect trust funds and to preserve them for the purposes designated by the donor. All hospital funds are trust funds and given substantially for the same purpose, which is for the maintenance of indigent patients in the institution. Dissipation of these funds by the awarding of damages certainly is not protection.

The conflict between these principles has produced in the past a great variation in the court decisions. Every decision has been an attempt to reconcile these two principles. We can omit here all discussion of the many decisions that have contributed to the development of a policy or tendency of the courts to unite on a definite position as a just compromise between these two principles. It is an interesting story but long. The fact only needs to be presented.

A recent decision of the Ohio Supreme Court (No. 16926—Decided January 24, 1922) sets forth this compromise clearer than others have done and states more concisely the guiding principle under which the decision (a unanimous one) was reached. It reads as follows:

"Where a public charitable hospital has failed to exercise due and reasonable care in the selection of physicians, nurses, or attendants and injury results from the incompetence or negligence of such persons, the hospital is liable."

In the development of this compromise came the recognition that trustees are obligated to make every reasonable effort to carry out the provisions of a trust, but no more. The trustees of the hospital and no others are the responsible trustees of funds given to the hospital in trust. A board of trustees cannot and is not competent to supervise every act of every agent of the hospital, but it can "exercise due and reasonable care" in the selection of all agents. To do less than this is to be false to the trust.

Such argument led to the present tendency of the courts to limit the liability of the hospital to the requirement that the responsible trustees shall "exercise due and reasonable care" in the selection of all agents, but after this has been done to absolve the hospital from responsibility for the acts of the agents so chosen.

Conclusion and answer to the question. The responsibility "to exercise due and reasonable care in the selection of physicians, nurses, and attendants" guarantees to the trustees full freedom to make this selection and in their own way. If they choose to announce their choice through an appointment to a staff or by inclusion on a

privileged list or in any other way, they may do so. The effect is the same: They made the selection and are responsible therefor. *A hospital* [illegible] *staff but is obligated "to exercise due and reasonable care" in the selection. The right to select carries with it the right to reject and for any reason their judgment may dictate.* The trustees carry all the responsibility.

Some who would recognize the right to appoint a staff would question the right of the hospital to refuse a licensed practitioner the privilege to treat a private patient in the institution. All court decisions known to the writer have brushed aside questions as to payments made or the status of the patient in the hospital. All patients in the hospital are pointedly classed alike. It is undoubtedly true that a hotel would find it difficult to exclude any licensed practitioner of medicine from treating any guest of the hotel. It is also likely that a hospital could not legally prevent a licensed practitioner from merely visiting and advising a patient, if this was desired by the patient. Such a situation, if objectionable, necessarily must be handled by the exclusion of the patient rather than the exclusion of the doctor.

But if the hospital grants to any physician the right to direct the work of any employee or attendant of the hospital, it clearly accepts this physician as its agent and is as responsible for him as for a full staff member. As it is quite impossible for a physician to treat a patient in a modern hospital without directing the work of nurses and other attendants of the hospital, the trustees necessarily assume full responsibility "to exercise due and reasonable care" in the selection of this agent when this privilege is granted. Again the responsibility to select carries with it the right to reject.

WORK OF THE HOSPITAL SURVEYOR

By E MURRAY BLAIR, M.D., Vancouver
Hospital Standardization Department, American College of Surgeons

IT seems to me the best method of approaching this subject is for you to go with me on an imaginary hospital visit, call on a hospital, and examine the points which we consider essential in arriving at a conclusion.

At our arrival we find that we are not unexpected and I want to bring out this point at the very beginning. It shows the attitude of the College visitor toward the hospitals; he invariably requests an interview by telephone. The College visitor does not telephone to the hospital and say, "I am coming"; there is no idea of dictation in any of our work at any time; it is suggestion from start to finish. We are there for your own good, we hope, and our suggestions are offered in good faith. If they are of value we want you to receive them; if they are of no value they are automatically dropped.

We ask for the minutes of the staff meetings from which we can glean a great deal. We ascertain the regularity of the meetings, the type of programs held, and the analysis of end-results. We find out, also, from the minutes, or in some other way, whether the staff has gone on record prohibiting the division of fees under any guise whatever. We must look for that and be sure that it is there and lay emphasis on it if it is missing.

During our visit to the wards we examine the current records to see whether they are stereotyped histories of questions answered "yes" or "no," or whether they are really accurate stories of the complaints. We want to know if there are complete physical examinations of all patients, regular progress notes, and accurate operation records.

In looking at the charts we look for a provisional diagnosis. We believe that a provisional diagnosis is important from many standpoints. When a patient is admitted there should be something definite on record to say why he is in the hospital. Another thing about it is that it is a splendid thing for a doctor to be able to go on record, and if he is wrong to *be* wrong. Recently a prominent physician said to me, "I think the most discouraging cases I have to meet are my patients which come to autopsy." We go over on the private side and look at the records in exactly the same way because we believe there should be no difference in the records for the public and the private patients.

An extraordinary thing in hospitals is the extreme lack of laboratory work that is found. Some very able men in this land seem to forget their laboratory work for some reason. In examining the equipment we want to feel that there is at least enough for the simpler experiments and as much more as possible. We want to know about the technician, about her supervision, and about the pathologist; we want to know about the facilities for the tissue work, whether done in the

hospital, and if not, where it is sent. There is no reason why laboratories should not be utilized to a greater extent. When I have talked to technicians about it, they have said, "Certainly, we are wrong; there is more we can do and we will do it." Our hospitals are built around our laboratories; each hospital is a scientific institution because it has a laboratory. The old idea of building a hospital around an operating room has gone. It is our duty to see that our laboratories are exploited as far as possible. The record room of the laboratory, also, is important. We want to feel that it is the headquarters for scientific work. We want to feel that all the work which goes on in the laboratory including the records thereof is well done.

We ask to see the record room where we study the record system, including the alphabetical index, disease index, and filing cabinets. We inquire as to the use made of the card indexes, for there is no use asking hospitals to put in an [illegible] them.

We will take 50 records at random, say within the last two or three months, and we will study them carefully, checking the percentage of personal histories, physical examinations, working diagnoses, operation records, progress notes, laboratory findings, and condition on discharge. At the end of our examination of the charts we call the superintendent in and discuss the results, so that there will be no misunderstanding.

The College visitor finds an enormous satisfaction in this work for there is something about it which you cannot find anywhere else. Every problem is a different one. We feel that we are in a work which is worth while. Our examination is based on an economic standpoint. We know that it is a great help wherever it is put into effect and that it is a stimulus to any hospital and to its patients. It undoubtedly affords the community a better place in which to be sick.

Published by
American College of Surgeons
Chicago, Illinois, U. S. A.